

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012405

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3325

DO NOT WRITE
ON THIS STUB

AMENDED

FILED APR 6 1962

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. LouisLength of stay in 1b
2 wks.c. CITY
OR
TOWN St. LouisInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION Homer G. PhillipsInside Limits
Yes ☒ No ☐d. STREET
ADDRESS 4601 GreerReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Amanda

Adams

4. DATE
OF
DEATH

Month

Day

Year

3

25

62

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

7-16-1882

9. AGE (last birthday)

79

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (City and state or country)

? North Carolina

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Sam Anderson

13b. MOTHER'S MAIDEN NAME

Armanda Roundtree

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Carrie Ella Brown

4601 Greer

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH
Undet.Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes☒ No☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 3-11-62

to 3-25-62

and last saw her alive on 3-25-62

Death occurred at 10:10

a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

2601 N. Whittier Street

22c. DATE SIGNED

3-26-62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

3-30-1962

23c. NAME OF CEMETERY OR CREMATORY

Shipped

23d. LOCATION (City, town, or county)

Clarksdale, Mississippi

(State)

FUNERAL DIRECTOR

ADDRESS

1212 North Grand

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

VS 300
Rev. 4/59

2009

2 210

3

4 3

5 2

6

7 1

8 2

9

10

11

12 77-0

13

77

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

William B. [Signature]

Licensed Embalmer No.

3962

P. O. Address

1221 N. [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.